Residential Treatment Expansion Consortium
REFERRAL/APPLICATION PACKET

Date:_____

Referring Source:

Name:_____

Company Name:_____

Address:_____

Phone #:_____ Cell #:_____

I/we are requesting admission for:

Patient Name:_____

Address:_____

Age:_____ Birthdate:_____

The above named is in need of admission for: (check all that apply)

___	Detoxification (Rimrock)	___	Crisis Stabilization (include Crisis admit form) (Rimrock)
___	Rimrock (3.1) Women's Beds	___	White Birch Residential Treatment (3.5) (Rimrock)
___	Elkhorn (3.5)	___	Lighthouse, Miles City
___	Blue Thunder Lodge, Great Falls	___	White Sky Hope, Rocky Boy
___	Olive Branch, Bozeman	___	Kalispell

He/she appears to have a co-occurring mental health problem/diagnosis:

____Yes ____No For (please specify):_____

Annual income is:_____ # of Dependents:_____ (including patient claimed)

State approved programs must submit the following:

- Completed Patient Information Form
- Placement Documentation Form
- Completed State Financial Eligibility Forms
- If available, a Completed Assessment

____**Admission Approved**

____**Admission Denied**

By:_____

Date:_____

____**# Initial Days, if approved**